

APPLICATION FOR ADULT SERVICES

PROGRAMS REQUESTED (Check all that apply):

Residential Programs

- ☐ Group Homes (Genesis/Pearl Street)
☐ Intensive Supportive Apartments
☐ Supportive Apartments
☐ Supported Housing

Case Management

- ☐ Intensive Case Management
☐ Supportive Case Management
☐ Dual Recovery Case Management

Psychosocial Club/Vocational Rehabilitation

- ☐ East Side Center
☐ Project C.H.O.I.C.E.
-

CLIENT INFORMATION:

Name:

Date of Referral:

Address:

City, State, Zip:

Phone (Home):

Phone (Cell/Work):

Sex:

DOB:

Social Security:

Medicaid/Medicare #:

Other Insurance:

Emergency contact:

Relationship:

Phone:

Please check all that apply:

- ☐ Functionally Disabled due to a Mental Illness
☐ SSI or SSDI Enrollment due to a Mental Illness
☐ Functionally Disabled in the Areas Indicated:
☐ Self-Care ☐ Activities of Daily Living ☐ Social Functioning
☐ Inability to Complete Tasks ☐ Self-Direction ☐ Economic Self-Sufficiency
☐ Regular and Ongoing Reliance on Psychiatric Treatment, Rehabilitation, and Supports

Referral Name/Source:

Relationship to Applicant:

Address:

Phone:

Fax:

Email:

Reason for referral at this time (please state specifically how these services are necessary for the applicant):

PSYCHIATRIC INFORMATION:

Currently in treatment? Yes ☐ No ☐ If no, what is barrier to treatment:

Clinical Treatment Agency:

Phone:

Therapist:

Psychiatrist:

Diagnosis: Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Does the applicant take medications as prescribed? Yes ☐ No ☐

Currently inpatient? Yes ☐ No ☐

Admit date:

Anticipated D/C date:

History of admissions? Yes ☐ No ☐

Dates of past admissions, if known:

RISK ASSESSMENT:

History of suicidal ideation, gestures, threats or attempts? Yes ☐ No ☐ Unknown ☐

History of homicidal ideation, gestures, threats or attempts? Yes ☐ No ☐ Unknown ☐

History of threats or acts of violence towards others? Yes ☐ No ☐ Unknown ☐

Please explain any responses marked "Yes" above and address the nature of any risk:

Early warning signs of decompensation:

HEALTH CARE:

Assistance needed? Yes ☐ No ☐ Unknown ☐

Medical Conditions:

Allergies:

Is there a PCP? Yes ☐ No ☐ Unknown ☐ Name: Phone:

Has a health care proxy been executed: Yes ☐ No ☐ Has an advance directive been executed: Yes ☐ No ☐

SUBSTANCE ABUSE:

Clinically relevant? Yes ☐ No ☐ Unknown ☐

Current use? Yes ☐ No ☐ Unknown ☐

Substance(s) of choice:

Length of sobriety:

Current Treatment? Yes ☐ No ☐ Unknown ☐ Current Provider:

Past Treatment? Yes ☐ No ☐ Unknown ☐ Past Provider(s):

LEGAL INVOLVEMENT:

History of legal or criminal involvement? Yes ☐ No ☐ Charges pending? Yes ☐ No ☐

Currently on probation? Yes ☐ No ☐ Currently on parole? Yes ☐ No ☐

Please explain any responses marked "Yes" above:

Probation or Parole Officer: Phone:

FINANCIAL MANAGEMENT:

Check if applicable: Medicaid ☐ SSI ☐ SSD ☐ PA ☐

Application pending for: Medicaid ☐ SSI ☐ SSD ☐ PA ☐

Please list any financial management needs, including rep payee status and income source:

LIVING ARRANGEMENT:

Homeless, or at risk of homelessness? Yes ☐ No ☐

Please list current living arrangement, including any current or pending subsidies:

Please assess applicant's ability to tolerate group living or a roommate:

VOCATIONAL/EDUCATIONAL FUNCTIONING:

Please list any vocational/educational goals and barriers to employment/school participation:

SOCIAL SUPPORTS:

Please note any current supports, such as family, friends, clubs, etc:

TRANSPORTATION:

Please list any current transportation needs:

Is individual aware of this referral? Yes ☐ No ☐

Is individual interested in services? Yes ☐ No ☐

Please note client strengths, skills, and interests:

ADDITIONAL COMMENTS:

Please add any additional comments:

Required information:

- ☐ Consent for release of information
- ☐ Psychiatric evaluation (within 1 year)
- ☐ Admission/discharge summaries and/or treatment plans (most recent)
- ☐ Physical exam with T.B. (Residential, East Side Center only)
- ☐ Functional assessment survey (Residential only)
- ☐ Signed physician authorization for restorative services (Residential only)

Please send form and information to:

SPOE Coordinator
Office of Community Services
230 Maple Street
Glens Falls, NY 12801
Phone: (518) 792-7143
Fax: (518) 792-7166

APPLICATION FOR ADULT SERVICES

This application is for use in referring individuals to residential, case management and psychosocial/vocational programs funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties. Service providers include Warren-Washington Association for Mental Health and Behavioral Health Services of the Glens Falls Hospital.

Group Homes are targeted for those in the earliest stage of recovery who would benefit from short-term, focused skill development in a home-like setting. *Intensive Supportive Apartments* are located in a single site apartment building and provide 24-hour staffing. *Supportive Apartments* are located in the community; staff provide services through regular visits and an on-call system. *Supported Housing* helps individuals with finding and maintaining permanent independent housing.

Intensive Case Management and *Supportive Case Management* assist adults with severe mental illness to access care and function in the community. *Dual Recovery Case Management* assists adults with severe mental illness, who have alcohol and/or drug problems, and who may be involved with the criminal justice system.

East Side Center offers vocational and pre-vocational programs, supportive counseling, recreation and socialization opportunities, educational trainings, and health workshops. *Project Choice* is a 12-week vocational program that helps individuals to make decisions about working.

The attached application should be filled out completely. In addition, please attach the following:

1. **Signed release(s) of information (including, if possible, releases of information covering other services with which the applicant is already involved)**
2. **Psychiatric evaluation (most recent; for Residential Programs, must be within one year)**
3. **Relevant admission and discharge summaries and current treatment plans (most recent)**
4. **Physical exam with Mantoux T.B. test (Residential Programs and East Side Center Only)**
5. **Functional assessment survey (Residential Programs Only)**
6. **Signed physician authorization for restorative services (Residential Programs Only)**

Availability of services is limited, and there may be a delay in receiving services even after an applicant has been determined to be eligible. If the referring agent or applicant is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and the programs it represents reserve the right to make the final determination.

The New York State Office of Mental Health sets residential program fees. Funding sources such as SSI, SSDI and Public Assistance adjust the recipient's support payment to ensure that the program fee is covered in the monthly payment. In order to process this application, please have the funding in place prior to admission to the residential programs. Other financial arrangements for private pay residents must also be in place prior to admission.

Completed applications and required documentation should be forwarded to:

SPOE Coordinator
Office of Community Services
230 Maple Street
Glens Falls, NY 12801
Telephone: (518) 792-7143
Fax: (518) 792-7166

After receiving the completed application, we will contact you as soon as possible regarding the next steps in the process. Thank you for your interest in our programs.

SINGLE POINT OF ENTRY AUTHORIZATION FOR RELEASE OF INFORMATION	Name (Last, First): DOB:
This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.	
Description of Information to be Used/Disclosed: General medical reports, social histories, psychosocial reports, psychiatric assessments, Individualized Educational Plans, psychological testing, other:	
Purpose or Need for Information: The purpose of this disclosure is for determination of eligibility for residential, case management and psychosocial/vocational programs funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties.	
From: Name, Address & Title of Person/Organization/Facility/Program Disclosing Information	To: Name, Address & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made The Single Point of Entry Committee (SPOE), comprised of representatives of community agencies including the Office of Community Services for Warren and Washington Counties, the Warren-Washington Association for Mental Health, Behavioral Health Services of The Glens Falls Hospital, Parsons Child and Family Center, St. Catherine's Center for Children, Northeast Parent and Child Society, Liberty House Foundation, Voices of the Heart, the Office for Persons with Developmental Disabilities and the Departments of Social Services for Warren and Washington Counties.
I hereby authorize the use or disclosure of the above information to the Person/Organization/Facility identified above. I understand that: 1. Only this information may be used and/or disclosed as a result of this authorization. 2. This information is confidential and cannot legally be disclosed without my permission. 3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected. 4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. 5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits. 6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 CFR§164.524).	
Please select one choice from either B-1 or B-2 B-1. One-time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above. My authorization will expire: <input type="checkbox"/> When acted upon; or <input type="checkbox"/> 90 Days from this Date. B-2. Periodic Use/Disclosure: I hereby permit the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above. My authorization will expire: <input type="checkbox"/> One year from this date; If neither B-1 nor B-2 is selected, this authorization will expire one year from this date.	
Patient Signature: I certify that I authorize the use of my health information as set forth in this document.	
Individual (or Child or Youth) (Name) _____ Date _____	Individual (or Child or Youth) (Signature) _____ Date _____
If applicable, Parent or Guardian (Signature) _____ Date _____	Witness (Signature) _____ Date _____

FUNCTIONAL ASSESSMENT SURVEY
****FOR REFERRALS FOR RESIDENTIAL SERVICES ONLY****

Information is based upon (please specify by circling):

1. Direct observation
2. Patient's own report
3. Other (please specify): _____

I. PSYCHIATRIC PROBLEMS

1 = no problem 2 = minor problem 3 = moderate problem 4 = severe problem

IN THE LAST YEAR HAS THIS PERSON EXHIBITED:	1	2	3	4
Somatic concerns (preoccupation with physical health, fear of illness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (worry, fear, heightened concern for present or future)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional withdrawal (lack of spontaneous interaction, isolation, deficiency in relating to others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual thought content or conceptual disorganization (odd, disorganized, bizarre or confused thoughts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension (motor manifestation, nervousness, hyperactivity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mannerisms, posturing (bizarre motor behavior)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hostility (animosity, contempt or belligerence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspiciousness (mistrust, belief that others harbor malicious intent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinatory behavior (perceptions without normal external stimuli)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor retardation (slowed, weakened movements or speech)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blunted affect (reduced emotional tone, reduction in normal intensity of feeling, flatness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excitement (heightened emotional tone, agitation, increased reactivity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation (confusion or lack of association for person, place or time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncooperativeness (resistance, guardedness, rejection of authority)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. BEHAVIOR

1 = no problem 2 = minor problem 3 = moderate problem 4 = severe problem

WITHIN THE LAST YEAR, DID THIS PERSON:

	1	2	3	4
React poorly to criticism, stress or frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respect limits set by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threaten physical violence to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage property to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage own property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Require one to one supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miss or arrive late for assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wander or run away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behave inappropriately in a group setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take or use other's property without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shown antisocial sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threaten harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. DAILY LIVING SKILLS

1 = independently 2 = reminders/assistance 3 = requires 1:1 supervision 4 = can't or will not

DOES THIS PERSON:

	1	2	3	4
Shop for personal necessities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage personal money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use social service agencies appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use social supports/community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devote proper time to tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in individual leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do own laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take medication as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Keep clinic or other appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use money correctly for purchases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform home maintenance/cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain an adequate diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain adequate personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use telephone correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke in a safe manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up promptly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend a day program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrate basic cooking skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. PROBLEM SOLVING AND INTERPERSONAL SKILLS

1 = independently 2 = reminders/assistance 3 = requires 1:1 supervision 4 = can't or will not

DOES THIS PERSON:	1	2	3	4
Apologize when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respect personal space of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Act assertively when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen and understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resolve conflicts appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise good judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan in cooperation with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treat own minor physical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtain help for physical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow through on advice of doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialize with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take initiative or seek assistance with problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Warren Washington Association for Mental Health

**AUTHORIZATION FOR RESTORATIVE SERVICES
IN COMMUNITY RESIDENCES
(*FOR RESIDENTIAL REFERRALS ONLY*)**

CLIENT'S NAME:

CLIENT'S MEDICAID NUMBER:

(if client is applying for Medicaid, please indicate by writing "PENDING")

PLEASE INDICATE WHAT TYPE OF AUTHORIZATION THIS IS:

☐ **INITIAL AUTHORIZATION** (Must be completed by a PHYSICIAN only and requires a face-to-face meeting between the authorizing Physician and the Client.)

FOR INITIAL AUTHORIZATION ONLY: Date of required face-to-face meeting between the authorizing Physician and the Client:

☐ **RE-AUTHORIZATION** (May be completed by a PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER IN PSYCHIATRY only)

I, the undersigned licensed Physician, or Physician Assistant or Nurse Practitioner in Psychiatry in the case of a Re-Authorization, based on my review of the assessments made available to me, have determined that would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR, which include:

* Assertiveness/self-advocacy
* Community integration
* Daily living skills
* Medication management

* Socialization
* Health services
* Symptom management
* Parenting training

* Rehabilitation counseling
* Substance abuse services
* Skill development

This authorization is for the following type of Mental Health Service within the noted time frame (please check the type of residential service for which the client is seeking admission and document the Effective Date and End Date of this authorization within the noted parameters):

☐ **COMMUNITY RESIDENCE:**
Authorization Effective Date: End Date: (no more than 6 months from Effective Date)

☐ **APARTMENT PROGRAM:**
Authorization Effective Date: End Date: (no more than 1 year from Effective Date)

MEDICAL PROFESSIONAL NAME (please print):

LICENSE NUMBER:

NATIONAL PROVIDER IDENTIFIER:

MEDICAL PROFESSIONAL SIGNATURE:

DATE OF SIGNATURE:

This completed authorization must accompany the residential services application.

THANK YOU